CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	A. BUII	LDING	ONSTRUCTION 01	(X3) DATE S COMPL 05/25/2 (ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE CULVER RD IN46534		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0000	A Life Safety Cand State Licer conducted by the Department of with 42 CFR 4 Survey Date: Facility Numb Provider Numb AIM Number: Surveyor: Rice Safety Code Spafety Code (In Safety Code (In Safe	Code Recertification Insure Survey was the Indiana State Health in accordance 83.70(a). 05/25/11 er: 000088 Der: 155686 100289260 thard D. Schade, Life pecialist fety Code survey, Center-Knox was compliance with for Participation in icaid, 42 CFR 0(a), Life Safety from 000 edition of the Protection IFPA) 101, Life LSC), Chapter 19, th Care Occupancies	K	0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	ľ	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER		300 E C	ddress, city, state, zip co CULVER RD IN46534	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	to be of Type I construction a sprinklered. Talarm system in the corridor rooms and spacorridors. The capacity of 57 54 at the time Quality Review by Safety Code Special 06/03/11. The facility we compliance we aforementione	The facility has a fire with smoke detection is, resident sleeping ices open to the e facility has a and had a census of of this survey. Robert Booher, REHS, Life list-Medical Surveyor on as found not in ith the				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155686	B. WING			05/25/2	011
	PROVIDER OR SUPPLIER		•	300 E C	DDRESS, CITY, STATE, ZIP CODE CULVER RD IN46534		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on obse interview, the ensure 2 of 2 s serving hazard corridor west or prevent the past deficient pract residents, visit near 2 of 3 smooth from the storage in t	d construction (with 3/4 hour ran approved automatic fire em in accordance with 8.4.1 otects hazardous areas. It dautomatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches if the door are permitted. Invation and facility failed to storage room doors lous areas in the main closed and latched to ssage of smoke. This lice could affect fors and staff in and toke compartments. Invations with the supervisor on een 1:40 p.m. and Toom across from 5 which contained it two natural gas	K0	0029	1. The storage room door had been corrected with a self clot device. The door to the soiled linen room will be replaced with 3/4 hour fire rated door and a closing device. The door has been ordered. 2. There are nother doors in the center that not meet the requirements. 3 During routine monthly safety inspections all doors will be reviewed for poper closing devices and door integrity. And door found to be out of compliance will be reported to safety commettee and report during the monthly QAA meed. The Maintenance Director be responsible for compliance August 15, 2011.	osing d ith a a self o do 3. / o the ed ting.	08/15/2011
	water heaters,	did not have a door					
	closer, and did	not automatically					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE			ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155686	B. WINC			05/25/20	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVING CENTER-	KNOX		KNOX, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAU	close and latch			IAG			DATE
		nen storage room					
	across from th	e lobby had a door					
	with slats and	did not automatically					
	close and latch	1.					
	The maintena	nce supervisor					
	acknowledged	the problem areas at					
	the time of obs	servation.					
	3.1-19(b)						
	3.1 17(0)						
K0062	Required automatic sprinkler systems are continuously maintained in reliable operating			İ			
SS=F							
		inspected and tested 7.6, 4.6.12, NFPA 13, NFPA					
	25, 9.7.5	7.0, 4.0.12, NITA 10, NITA					
	Based on obse	rvation and	K0	062	1. The upright sprinkler head		06/14/2011
	interview, the	facility failed to			were purchased and placed i spare sprinkler head cabinet.		
	•	plete supply of spare			An audit was conducted and		
	-	1 of 1 automatic			other spare sprinkler heads v	vere	
	1	ems in accordance			missing from the cabinet. 3. During the monthly safety		
		, 1998 Edition 2-4.1.4			inspections the spare sprinkle	er	
					head cabinet will be checked		
	•	s a supply of at least			the proper number and types heads. If any are found missi		
		klers shall be stored			they will be replaced and this		
		the premises for			be reported to the safety		
		urposes. The stock of			committee and the QAA committee. 4. The Maintenar	,,	
	spare sprinkler	rs shall be			Director will be responsible for compliance. 5. Corrected June		
	proportionally	representative of the					
1 2 2		perature ratings of the			14, 2011		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	onstruction 01	(X3) DATE SURVEY COMPLETED	
		155686	A. BUILDING B. WING		05/25/2011	
NAME OF I	PROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	KNOX	l l	CULVER RD IN46534		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETI DATE	ION
		ers. A minimum of				
	1	of each type and				
	temperature ra	ting installed shall be				
	provided. This	s deficient practice				
	could affect al	l of the residents as				
	wall as staff ar	nd visitors in the				
	event of an em	nergency.				
	Findings include: Based on observation with the maintenance supervisor on					
		ng the tour at 1:50				
		re no spare upright				
	_	ne spare sprinkler				
	cabinet. The r					
	supervisor stat	ted at the time of				
	observation, he	e was not aware of				
	the omission o	of upright sprinklers.				
	3.1-19(b)					
K0067		g, and air conditioning				
SS=E	are installed in acc	ovisions of section 9.2 and cordance with the				
	manufacturer's spo					
	NFPA 90A, 19.5.2 Based on obse		K0067	1. Upon careful review the fa	cility 08/01/2	011
		facility failed to		has determined that a waive	is	
	•	corridors were not		not needed. We have contact and D Property Specialists w		
	3	-				

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06/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155686 05/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 E CULVER RD **GOLDEN LIVING CENTER-KNOX** KNOX. IN46534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE are in the process of preparing a used as a portion of a return air proposal for this facility. 2. In system serving 2 adjoining rooms preparing the proposal, the facility of more than 50 rooms. LSC Maintenance Director conducted a review of all return air ducts and 19.5.2.1 requires air conditioning. determined that there was an heating, ventilating ductwork and additional need for a return air duct in the office of the related equipment to be installed in administrator. The Maintenance accordance with NFPA 90A, the Director, with the assistance of the engineer from T and D. Standard for the Installation of Air determined that if the ceiling tile Conditioning and Ventilating was replaced a return air duct would not be required in the Systems. NFPA 90A, 2-3.11.1 barber shop. 3. The facility will be requires egress corridors shall not installing return air ducts in the be used as a portion of a supply, Social Service and the Administrators office. It is return, or exhaust air system estimated that this work will take serving adjoining areas. This approximately 3 weeks from the date the contract is signed. 4. deficient practice could affect all The Maintenance Director will residents, staff and visitors in and monitor all drop ceilings for broken or missing tiles. Any items near the barber shop and social found will be corrected and services office. reported on the monthly safety inspection. 5. August 1, 2011 Findings include: Based on observations on 01/05/11 between 11:00 a.m. and 12:45 p.m. with the facility administrator and maintenance supervisor, the barber shop and social services office were using the egress corridor as a return air system. Heating and cooling are supplied by vents in the corridor

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SKTZ21

Facility ID:

880000

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		155686	B. WIN			05/25/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	KNOX			IN46534		
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K0069 SS=E	and rely on the ventilation. The supervisor ack deficiency and aware of the personal state of the personal state of the personal state of the containers. For Ventilation Protection of CO Operations, 19 says grease filts specific orients shall be clearly the hood shall filters cannot be	are protected in accordance 2.6, NFPA 96	KO	TAG	1. The grease filter panels habeen properly installed into the exhaust hood as of June 14, 2011. 2. No ther areas in the exhaust hood were affected. The maintenance department be responsible to see that the grease filters are properly plain the hood after each cleaning During the monthly safety inspection the Maintenance Director will review for filter placement and report to the safety committee and the QA committee, any irregularities. Completed June 14, 2011.	ave ne 3. t will e aced ng. 4.	DATE 06/14/2011
	practice could	affect kitchen staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155686		155686	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/25/2011		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN46534				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION		
	and any reside adjoining dining	nts or visitors in the ng room.					
	Findings inclu	de:					
	maintenance so 05/25/11 at 12 two sets of gree of the correct of grease from the maintenance so the time of obs	ase filter baffles were prientation to drain e exhaust hood. The apervisor stated at servation, he was not rect orientation for					
K0070 SS=F	in all health care o non-sleeping staff the heating elemen	ating devices are prohibited ccupancies, except in and employee areas where nts of such devices do not es F. (100 degrees C)					
	protect 57 of 5 having a policy the use of port	rd review and facility failed to 7 residents by not y and procedure for able space heaters. practice could effect	K0070	The Executive Director provided a policy on the use space heaters. 2. The only heaters in the building are offices of the Executive Di Director of Nursing, MDS as Dietary. An audit was conducted by the Mainten Director and no other space.	se of y space in the rector, as well		

880000

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155686	A. BUILDING	01	05/25/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		l l	CULVER RD	
	I LIVING CENTER-	KNOX	KNOX,	IN46534	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
		taff and visitors.		heaters were found in the	
	Findings inclu			building. 3. The policy on spa heaters will be approved by to QAA committee and then pla in the safety manual. The Maintenance Director will ad-	the aced
	Based on obse	rvations between		check to his monthly safety of	l l
	11:50 a.m. and			list. Any violations of the fac	ility
		the maintenance		policy will result in the heater being removed and the ED a	
	supervisor and facility			the safety committee being	
	_	the facility could not		notified of the infraction. Aud results will be shared with the	
	produce evidence of a policy and procedure for the use of portable			QAA committee when an	
				infraction occurs. 4. The	
	•	Space heaters were		Maintenance Director is responsible for compliance w	vith
	_	e Director of Nursing		this item. 5. Corrected June	I
		ministrator's office		2011.	
	· ·	of of the main lobby.			
		ator stated at the time			
		tions, he thought he			
	had a policy by	•			
	evidence of on	•			
	evidence of on	IC.			
	3.1-19(b)				
K0144 SS=F		spected weekly and bad for 30 minutes per name with NFPA 99.			
	1. Based on re	ecord review and	K0144	The facility has secured a	06/25/2011
	interview, the	facility failed to		letter from NIPSCO which complies with the items requ	ired
	ensure the off	site fuel source for 1		in NFPA 110, 1999 Edition	
		y generators was		Chapter 3, 3-1.1.2. The rem enunciator panel will be instaby June 20, 2011. The staff	alled
				1 by build 20, 2011. The stall	*****

880000

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155686	A. BUI	LDING	01	COMPL 05/25/2	
		100000	B. WIN		DDDDGG GITH GTATE ZID GODE	03/23/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
	N LIVING CENTER-				IN46534		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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1710	•	e source. NFPA 110,		1710	be inserviced as to how to us	se	DALL
	1999 Edition,				the panel and what is require		
	1	d Standby Power			them to do when the panel g into alarm. The enunciator p		
		oter 3, Emergency			will be located in the East nu		
	Power Supply (EPS), 3-1.1, Energy				stations. 3. The emergency light log for the generator are		
		the following energy		has been found.		ute	
		pe permitted for use			test took place on June 1, 20 and again on June 1, 2011.		
	for the emerge	ency power supply			have sent a copy of the log v	vith	
	(EPS):				this response. 4. The Maintenance Director is		
	a) Liquid Pet	roleum products at			responsible for all of the abo		
	atmospheric p	ressure			items. He will be responsible making sure the NIPSCO let		
	b) Liquefied	petroleum gas (liquid			maintained in the Survey		
	or vapor with				Readiness Book. Monthly, h check the enunciator panels	e will	
	c) Natural or	· ·			operation as part of the facili	ty	
	Exception: Fo	or Level 1			safety check. Lastly, he will		
	installations in	n locations where the			conduct the 90 minute check each year and record the res		
	probability of	interruption of off			in the monthly safety check r		
	site fuel suppl	ies is high (e.g., due			that goes to the safety command the QAA committee. 5.		
	to earthquake,	flood damage or			25, 2011.		
	demonstrated	utility unreliability),					
	on site storage	e of an alternate					
	energy source	sufficient to allow					
		the emergency power					
	supply system						
	delivered for t	he class specified					
	shall be require	red, with provision for					
	1	sfer from the primary					
		to the alternate					
		. CMS requires					
		*					

000088

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 01	(X3) DATE S COMPL	
ANDILAN	or connection	155686	A. BUII			05/25/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER				CULVER RD		
GOLDEN	I LIVING CENTER-	KNOX		KNOX,	IN46534		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	DATE
	evidence of rel	liability of the natural					
	fuel source mu	st contain all of the					
	following:						
	1. A statement of reasonable						
	reliability of the natural gas						
	delivery;						
		cription the supports					
	the statement i	regarding the					
	reliability;						
	3. A statement there is a low						
	*	interruption of the					
	natural						
	gas;	• • • • • • • • • • • • • • • • • • • •					
		cription that supports					
		regarding the low					
		of interruption;					
	_	are of technical In the natural gas					
	vendor.	ii tiie naturai gas					
		practice could affect					
		taff and visitors.					
	an residents, s	wil wild vibitold.					
	Findings inclu	de:					
	Based on recor	rd review and					
	interview with	the maintenance					
	supervisor and	I facility					
	administrator a	at 11:15 a.m. on					
	05/25/11, the f	fuel source for the					
	L						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	COMPL	
		155686	A. BUI B. WIN	LDING IG		05/25/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	KNOX			ULVER RD IN46534		
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	emergency gergas and the factorial letter from the provider stating for the general source. The active time of receiver from NII not be found. 3.1-19(b) 2. Based on or interview, the ensure 1 of 1 grace accordance with Edition, Stand Facilities. NF 3-4.1.1.15 requand annunciator to location readily operating persystems.	bservation and facility failed to generator sets was in th NFPA 99, 1999 and for Health Care PA 99, Section uires a remote be provided in a y observed by onnel at a regular This deficient affect all occupants including staff, sidents.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVING CENTER-KNOX (X4) ID SUMMARY STATEMENT OF DEPICIENCIES TAG Based on observation on 05/25/11 between 12:25 p.m. and 1:40 p.m. with the maintenance supervisor, a generator annunciator panel was not located at either of the two nurses stations. The maintenance supervisor stated at the time of the observations, he was not aware of the requirement. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure emergency task lighting in and around 1 of 1 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686			LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/25/2011	
COLDEN LIVING CENTER-KNOX KNOX, IN46534	NAME OF I	PROVIDER OR SUPPLIEI	<u> </u> 		STREET A			_
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Supply) equipment locations shall		requires EPS	(Emergency Power					
		_						
		be provided w	rith battery powered					
emergency lighting. This deficient		emergency lig	hting. This deficient					
practice could affect all residents,		practice could	affect all residents,					
staff and visitors in the facility.		staff and visite	ors in the facility.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 05/25/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN46534				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	Findings inclu	de:					
	maintenance s 05/25/11 at 11 maintenance s acknowledged the battery por	:30 a.m., the upervisor he had no record of wered light at the g tested for 90					